

Methods In addition to using our “Moodle” page as a repository for training information, rotation and teaching event details and Journal club records we have also developed Endoscopy and Gastro-radiology atlases.

Forums for Case, Endoscopy and Radiology Presentations have also been developed, and these are “Question and Answer” forums in which trainees post a short introduction and others reply with their thoughts. Other trainee’s postings become visible once an individual has posted themselves, thus removing the chance that all replies will mirror that of the first reply. As the discussion progresses the case is updated by the original poster to mirror how the case developed in real life.

To augment the learning during regional teaching, quizzes are placed on the VLE following each session and immediate feedback is given. Teaching evaluation is also obtained through the VLE which simplifies the analysis of this feedback.

We have surveyed how the trainee’s use the VLE and which areas they find most useful via a questionnaire in order to guide further development.

Results Pleasingly all trainees were aware of the existence of a VLE for Gastroenterology and have accessed it at some stage. The case discussion forums are used most and found useful by all trainees. All those who have used the Endoscopy and Radiology libraries find them useful, and all trainees report finding the Journal Club records and the single point of access for training information, e-learning resources and rotation details useful. The quizzes following teaching sessions were seen as less helpful, but two thirds still found them to be useful. The medical apps area is not used by any trainees and this may relate more to the ready access to medical apps available on smart phones.

Conclusion The interactive use of the VLE has been accepted by most trainees and has led to evidence based discussion around cases and consolidation of learning together with providing a repository for the storage of information and resources. The “moodle” platform requires only simple IT skills and material can be developed by anybody with basic word processor skills. Further development is planned that will include blueprinting of the curriculum to the rotation and learning material available, together with further interactive case discussions.

Disclosure of Interest None Declared

PTU-005 AGREEING ENDOSCOPY TRAINER ATTRIBUTES – A DELPHI STUDY TO DEVELOP A TRAINER EVALUATION TOOLKIT

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Introduction Recent advances have been made to improve the skills of the UK’s endoscopists but currently endoscopy trainers have no validated method by which to receive formative feedback regarding their training. Previous research has developed a list of attributes that describe the high quality trainer and could be used to deliver frequent feedback¹. This study uses the Delphi technique to select and refine attributes to be included in an evaluation toolkit. The Delphi technique is a group consensus technique that involves asking a panel to take part in a series of rounds to clarify, refine and finally gain consensus on an issue.

Methods Four sub-groups (experts, trainers, nurse endoscopists and trainees) reviewed the list of attributes that describe good endoscopy trainers derived from previous work¹. Participants were asked to suggest additions or modifications and rate the suitability of each attribute for two types of evaluation instrument: a single session (DOTS: directly observed teaching skills) or a rotation (LETS: long-term evaluation of teaching skills). After round one free text comments were analysed, additional items added and suggested modifications were made; attributes which scored less than

77% agreement were excluded; those that scored above 77% and had significantly different scores for the LETS and DOTS were allocated to the appropriate instrument. The remaining attributes were resubmitted to the panel in round 2

Results 62 participants completed the process. Following free-text analysis it was apparent that the panel wanted tools that were as short as possible. The attributes were therefore re-grouped and similar attributes amalgamated. Remaining comments were reviewed and subsequent modifications made, 17 attributes were excluded in round 1; 8 were allocated to the DOTS and 9 to the LETS. In round 2 a further 12 attributes were allocated to the DOTS and 6 to the LETS and one new item added

Conclusion By conducting this study it has been possible to develop a usable evaluation toolkit by which trainers could gain formative feedback on their performance. The Delphi process has enabled us to reduce the number of attributes included in the toolkit and refine these attributes. It has also enabled us to gain and amalgamate the opinions of a large panel of experts. Due to suggestions made by the panel, the original wording of 13 of the attributes was refined. Five attributes have resulted from an amalgamation of attributes

Disclosure of Interest None Declared

REFERENCE

1. Wells, C., *The characteristics of an excellent endoscopy trainer*. *Frontline Gastroenterology*, 2010. **1**: p. 13–18.

PTU-006 USING DIGISTORIES TO CHALLENGE STUDENT ATTITUDES TO ADDICTION

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Introduction Addiction to both alcohol and other drugs creates a large health burden within the NHS. Undergraduate exposure to these patients tends to be opportunistic and sporadic; we wanted to create a learning experience for large groups of 30+ students using a real patient storey. Patients with drug and alcohol dependence can lead chaotic lives and may feel threatened by a large group teaching encounter, they may struggle to talk about their often highly personal experiences. Moreover patients with addictions may only volunteer for teaching once they have been abstinent and consequently their storey whilst relevant is no longer current.

Methods A transdisciplinary group of Gastrointestinal and Mental Health teachers elected to produce a digital storey (digistory) of a patient currently dependent on both alcohol and opiates. A digistory is a personal narrative normally set to still images which change in reference to the person’s storey. Typically it is recorded using a Dictaphone and embedded within a PowerPoint picture presentation. The advantage of a digistory over conventional video is that the patient’s anonymity is preserved whilst the patient retains their own voice; the addition of appropriate images makes the storey more powerful and creates a focus whilst listening to the audio.

A patient known to a regional addictions service was approached, consented and recorded. The digistory was shown to the patient prior being shown to the students.

In groups students discussed their previous experiences of addiction and then watched the digistory. To enhance knowledge transfer they were asked to consider a biopsychosocial problem list for the patient. They then reflected on their own preconceived ideas about addictions, reaction to the storey and developed a patient problem list.

Students completed a written evaluation of the session.

Results There was consensus that the digistory was a powerful learning tool and that the session was thought provoking. Furthermore they stated that the storey’s power arose from the fact the

patient was a similar age to them and was local to the area. Students fed back in post-session evaluation that it had changed their perception of those with alcohol and drug problems.

Conclusion Some students did state a desire to still see patients for themselves; seeing patients personally will always remain important but we describe the use of a digistory as a powerful teaching tool to generate dialogue amongst learners, enhance knowledge exchange and address possibly misplaced attitudes to a vulnerable patient group. We recommend the use of digistories as a novel and effective teaching method to enable patients to tell very personal storeys whilst still protecting their anonymity.

Disclosure of Interest None Declared

PTU-007 EVALUATING ENDOSCOPY TRAINERS; HOW RELIABLE ARE PEER EVALUATORS?

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Introduction The training of future endoscopists is important to ensure the ongoing provision of a safe endoscopy service within the UK; however endoscopy training is of a variable standard. Peer evaluation can be used to improve teaching but this does not currently routinely occur in local endoscopy units. We therefore wanted to assess the reliability of peer evaluations using an evaluation tool currently being developed to gain both trainee and peer evaluations.

Methods The DOTS tool has been developed using the list of attributes described by Wells¹. In order to gain an assessment of reliability the tool was trialled on JAG approved Training the Trainer courses. Courses from November to March 2012 were contacted and asked to participate. Each course attendant was then sent an information letter and consent form. On day two of the course participants were asked to complete a copy of the DOTS for each of the training episodes they observed.

Data was analysed using SPSS 14; mean score and Cronbach alpha were calculated. Reliability was calculated using Generalisability theory; an initial analysis was performed using only trainers, peers and trainer: peer interaction as facets. A further analysis was then conducted including all possible sources of variance.

Results Eight of the ten courses contacted agreed to participate; all course participants consented to the study. 189 evaluations were collected; these were completed by 58 different peers; 45 trainers were evaluated receiving from one to ten evaluations each. Mean total evaluation score was 63.3 (out of 85); standard deviation 8.6. The tool showed a high level of internal consistency with a Cronbach alpha of 0.895. In the initial analysis 44% of the variance of scores was explained by the difference in trainers' ability to teach, 35% due to peer variance and 21% by peer:trainer interaction. The G-coefficient for one rater was 0.44 and three raters were required for a G-coefficient of 0.7. When the analysis was repeated the effect of course accounted for 20% of the variance in scores. Reliability was much lower with a G coefficient of 0.28 for one rater.

Conclusion The DOTS tool showed a high level of internal consistency. On initial analysis only three peer reviewers were required to gain acceptable levels of reliability. However on reanalysis the effect of course was responsible for the 20% of the variance and if results were generalised across course then the tool showed poor reliability. The effect of course was unexpected and needs to be investigated further; the tool also needs to be trialled within local units.

Disclosure of Interest None Declared

REFERENCE

1. Wells, C., *The characteristics of an excellent endoscopy trainer*. *Frontline Gastroenterology*, 2010. 1: p. 13–18.

PTU-008 SIMULATED ENDOSCOPIC TRAINING: HOW JUNIOR DOCTORS UTILISE THIS RESOURCE

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Introduction Simulation is increasingly being recognised as an attractive tool to support endoscopic training. Standard training has been associated with certain limitations; longer procedural times, cost, unpredictable pathology and occasionally patient dissatisfaction. Use of endoscopic simulators, has been suggested as alternative training method. Although advocated by national and international endoscopy societies (BSG, ASGE), when and how it should be incorporated into endoscopic training is still debated. A recent Cochrane review, suggested it was of most benefit to novice endoscopists.

An endoscopic simulation programme has been established at the Royal Free simulation centre since 2009. Completion of the course is not a formal speciality training programme requirement. Enrolled trainees progress through a staged curriculum with frequent assessment of their endoscopic competencies. How junior trainees use this resource was explored in this study.

Methods All trainees that have undertaken endoscopic training at the simulation centre between 2009 and 2012 were invited to complete an anonymous online questionnaire. Subsequently a targeted focus group was conducted; participants included trainees and simulation centre trainers.

Results 62 trainees were invited to complete the survey, with a response rate of 48% (30/62). The majority of trainees (93%; 28/30) completed the course during evenings or at weekends. 77% self-funded the course and just 7% obtaining study leave. Trainees enrolled on the course for a median of 2 months. 52% (15/29) were studying for a postgraduate exam while completing this course and 1 in 5 trainees commuted from outside the M25 to attend the course. A third of trainees were undertaking a rotation in Gastroenterology when they enrolled on the course and 82% (22/27) wanted to pursue a career in Gastroenterology. 68% (17/25) reported they were actively applying for Gastroenterology or Surgical registrar training posts in the next 12 months. Frequently cited course outcomes by trainees included; greater familiarity with endoscopic equipment and technique, an opportunity to gain basic endoscopic skill training as a foundation doctor or SHO, improved individual time management skills and was an opportunity for trainees to demonstrate a relevant example of commitment to speciality.

Conclusion Trainees completing this course cited a broad range of perceived learning outcomes. In addition to gaining endoscopic skill training, completing the course enabled trainees to develop their interpersonal skills and demonstrate commitment to speciality. This study supports junior doctors undertaking simulated endoscopic training.

Disclosure of Interest None Declared

PTU-009 FROM ABSTRACT TO FULL PUBLICATION: A 15-YEAR REVIEW OF BRITISH SOCIETY OF GASTROENTEROLOGY (BSG) CONFERENCE OUTCOMES

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Introduction Abstract presentations at scientific meetings allow rapid dissemination of novel research and enables peer review before submission for publication. Not all abstracts are subsequently published in peer reviewed journals. The likelihood of subsequent full publication of abstracts from other medical speciality meetings has